Within corporate limits

Dr. Oliver Jones

10001

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months

Hospital, institution, or street address where death occurred:
215 Valley St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Eckhart Mines
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Mary Elizabeth Allen

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: William T. Allen

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): September 18, 1882

8. AGE: Years	Months	Days	If less than one day
66	0	18	hrs. min.

9. Birthplace: Allegany County, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Henry Klosterman
13. Birthplace: Allegany Co., Md.

MOTHER
14. Maiden name: Mary Myers
15. Birthplace: Allegany Co., Md.

16. Informant: George B. Allen

Address: Eckhart Mines, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 9, 1948 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg, Md.

18. Funeral director: Joseph A. Lee

Address: Frostburg, Md.

19. Oct 7, 1948 (Date rec'd by registrar) Wm. L. Hauck M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6, 1948 at 8:20 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1948 to Oct. 6 1948 and that I last saw h[illegible] alive on Oct. 6 1948

Immediate cause of death	DURATION
Metastatic Adeno carcinoma	10 Mos.
Due to: Uterine adeno carcinoma	About 1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Adeno carcinoma of uterus

Date of op. 1935

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arthur T. Davis M.D. M. D. or other

Address: 110 S. Centre St. Date signed: 10-7-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10002

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 6 — Bowling Green

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas Anthony Assif

3.(b) Social Security Number: 214-05-5319

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Helen Byrd

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): July 4, 1895

8. AGE: Years	Months	Days	If less than one day
53	3	7	...hrs. ...min.

9. Birthplace: Syria (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Own business

FATHER — 12. Name: Charles Assif

13. Birthplace: Syria

MOTHER — 14. Maiden name: Anna Thomas

15. Birthplace: Syria

16. Informant: Mrs. Helen Assif

Address: Rt. 6, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 13, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hoffman

Address: Cumberland, Md.

19. Oct. 13, 1948 (Date rec'd by registrar) W. L. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1948, at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1948, to October 11 1948 and that I last saw him alive on Oct - 11 - 1948

Immediate cause of death	DURATION
Carcinoma of stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: John N. Rozum M.D. (M. D. or other)

Address: Cumberland Md. Date signed: 10/12/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10003

93d

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Rural - LaVale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Years

Hospital, institution, or street address where death occurred:
Gramlich Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural - LaVale
(If outside city or town limits, write RURAL and give nearest town)

Street No. Gramlich Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Albert Beckman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Beard

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 22, 1863

8. AGE:

Years	Months	Days	If less than one day
85	1	18	hrs. min.

9. Birthplace: North Glade, Garrett Col, Md.
(Town, county, and state)

10. Usual occupation: Labor Supervisor - Retired

11. Industry or business: Tin Mill

FATHER
12. Name: Theodore Beckman
13. Birthplace: Near Swanton, Garrett Col, Md.

MOTHER
14. Maiden name: Louisa O'Brien
15. Birthplace: Accident, Garrett Co., Md.

16. Informant: Albert E. Beckman
Address: 222 N. Hampshire Ave., Cumb., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/12/48 (month) (day) (year)

Cemetery or crematory: North Glade Cemetery

Location: North Glade, Md.

18. Funeral director: Otha F. Sharpless

Address: Blaine, W. Va.

19. Oct 12, 1948 (Date rec'd by registrar) W. F. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 10 19 48 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3 19 48 to Oct. 10 19 48 and that I last saw h[illegible] alive on October 8 19 48

Immediate cause of death	DURATION
congestive heart failure	2 months
Due to: arteriosclerotic heart disease	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. Whipp MD M. D. or other

Address: 5 E Second St. Date signed: 10-12-48

Within corporate limits

10004

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 Years
Hospital, institution, or street address where death occurred: 609 Henderson Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 609 Henderson Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MRS. DELERA M. BISHOP

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Divorced

6.(b) Name of husband or wife: John Bishop

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1880

8. AGE: Years: 68 Months: 1 Days: 4 If less than one day: hrs. min.

9. Birthplace: Chaneyville, Bedford Co. Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Austin Hartsock
13. Birthplace: Bedford Co. Pa.

MOTHER
14. Maiden name: Nancy Robinette
15. Birthplace: Bedford Co. Pa.

16. Informant: Mr. Ralph Bishop
Address: 542 N. Mechanic St. Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct. 12, 1948
(month) (day) (year)
Cemetery or crematory: Hillcrest Burial Park
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Oct. 11, 1948
(Date rec'd by registrar)
Carl Lantz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9 1948 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1948 to Oct 8 1948 and that I last saw h.e.r. alive on Oct 8 1948

Immediate cause of death: Pneumonia Myocardial Damage

DURATION: 7 da.

Due to: Arterio Sclerosis — 5 yr.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed: 10-9-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

10005

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Hrs. & 15 min.

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 2 1/4 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County: Delaware

City or town: Chester
(If outside city or town limits, write RURAL and give nearest town)

Street No. 209 Sunnyside Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles Gordon Brown

3.(b) Social Security Number: 171-10-9548

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Margaret M.D.Brown

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Dec.31-1904

8. AGE: Years: 43 Months: 9 Days: 4 If less than one day: ....hrs. ....min.

9. Birthplace: Chester Pa.
(Town, county, and state)

10. Usual occupation: Truck driver

11. Industry or business: Nu Car carrier

FATHER — 12. Name: Charles Brown

FATHER — 13. Birthplace: Chester Pa.

MOTHER — 14. Maiden name: Nellie G States

MOTHER — 15. Birthplace: Chester Pa.

16. Informant: wife) Margaret M.D.Brown

Address: Chester Pa. 209 Sunnyside Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 6 1948 (month) (day) (year)

Cemetery or crematory: St Michael Cem

Location: Chester Pa.

18. Funeral director: Louis Stein Lee

Address: Cumberland Md

19. Oct 5 1948 (Date rec'd by registrar) C.R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5 1948 at 8.40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....1948, to ....1948, and that I last saw him Dead Oct. 5 1948

Immediate cause of death: Intra abdominal hemorrhage & Shock. — DURATION: 7 hrs.

Due to: Multiple fractures of the pelvis & leg.

Due to: Auto truck hit center post on Pa. Turnpike.

Other conditions: Multiple abrasions & contusions of face & scalp
(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: aas above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Truck Accident Date of: 10-5-48

Where did injury occur? near Bedford (City or town) Bedford (County) Pa (State)
12 Miles west.

Injured at home, farm, industry, public place (where?): Pa. TurnPike pole

Means of injury: Truck struck center Did injury occur while at work? yes

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V. Deming M.D. H V Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed: 10-5-48

Within corporate limits

Dr. E. Brings

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10006

119a

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Near Cumberland, Rural (If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. 2, Willowbrook Road (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joan Carolyn Brown

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 14, 1948

8. AGE:

Years	Months	Days	If less than one day
0	0	17	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany, Md (Town, county and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Not given

13. Birthplace

MOTHER

14. Maiden name: Ruth Brown

15. Birthplace: Cumberland, Md

16. Informant: Ruth Brown

Address: Rt. 2, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 2, 1948 (month) (day) (year)

Cemetery or crematory: Hite Cemetery

Location: Cumberland, Md., Rural

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Nov 2, 1948 (Date rec'd by registrar) W. R. Stanley, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1948, at 10:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30 1948 to October 31 1948

and that I last saw h.. alive on October 30 1948

Immediate cause of death	DURATION
enterocolitis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Elizabeth Groves M.D. (M. D. or other)

Address: La Vale Date signed: 11/2/48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10007

134a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 Years

Hospital, institution, or street address where death occurred: 164 North Centre St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 164 North Centre St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rosanna Campbell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Holloway W. Campbell

6.(c) If alive, give age: 90 years

7. Birth date of deceased (mo., day, yr.): November 5 1889

8. AGE: Years	Months	Days	If less than one day
58	11	29	..... hrs. ..... min.

9. Birthplace: Nelson County, Virginia (Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER — 12. Name: Nelson A. Harris

13. Birthplace: Nelson County, Virginia

MOTHER — 14. Maiden name: Virginia Riffle

15. Birthplace: Nelson County, Virginia

16. Informant: Troy Campbell

Address: 164 N. Centre St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 17, 1948 (month) (day) (year)

Cemetery or crematory: Hill Crewt Burial Park

Location: Cumberland, Maryland

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct. 15 1948 (Date rec'd by registrar) Wm. Crawley, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14 1948, at 9-25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947 to Oct 14 1948 and that I last saw h[illegible] alive on Oct 14 1948

Immediate cause of death	DURATION
Abscess Left Kidney	6 wks
Due to Chronic Pyelonephritis	15 yrs
Due to Diabetes Mellitus	7 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

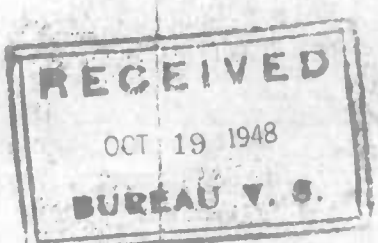
Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. Allan G. Murray M. D. or other

Address: Cumberland Md. Date signed: Oct 15 1948

Murray



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10008

CERTIFICATE OF DEATH

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

104 W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: RD # 2 Midland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Frostburg Maryland

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Walker Chapman

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret Keira

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 24, 1865

8. AGE:

Years	Months	Days	If less than one day
83	7		hrs. min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: Retired Miner

11. Industry or business: Coal Mines

FATHER

12. Name: George Chapman

13. Birthplace: Scotland

MOTHER

14. Maiden name: Jean Walker

15. Birthplace: Scotland

16. Informant: Mrs. R. B. Rowe

Address: 104 W. Main St, Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-26-48 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg Md

18. Funeral director: Jacob J. Hafer

Address: Frostburg Md

19. 10-26 19 48 Mrs. Harvey K. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 19 48, at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23 19 48, to October 24 19 48

and that I last saw him alive on October 24 19 48

Immediate cause of death: Coronary heart-disease — DURATION: 3 hrs.

Due to: Arteria-sclerosis

Due to: Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other

Address: Frostburg, Md. Date signed: 10/25/48

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

115 lb

10009

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
R.D.#1.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D.#1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James B. Collins

3.(b) Social Security Number: 214-01-0173

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret ConwayCollins

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Aug. 20, 1902

8. AGE: Years	Months	Days	If less than one day
46	2	1	...hrs. ...min.

9. Birthplace: Mt. Savage, Md.
(Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: Hotel

FATHER
12. Name: Daniel J. Collins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary McDermott
15. Birthplace: Maryland

16. Informant: Mrs. Margaret Collins
Address: R.D.#1 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 25, 1948 (month) (day) (year)

Cemetery or crematory: St. Patricks

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Oct 23 1948 (Date rec'd by registrar) W.R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 21, 1948 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 17. 48 1948 to Oct. 21. 48 1948 and that I last saw him alive on Oct. 21st. 1948

Immediate cause of death	DURATION
Septicemia.	36 Hrs.
Due to: Severe Strep Throat.	72 Hrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. Matthias M.D.
M. D. or other

Address: 146 Bedford St Date signed: 10/22/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92 L

10010

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Hugh Augustine Cunningham

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): July 19, 1930
8. AGE: Years: 18 Months: 2 Days: 12 If less than one day: ... hrs. ... min.
9. Birthplace: Midland, Allegany Co., Maryland (Town, county, and state)
10. Usual occupation: Student
11. Industry or business: La Salle Institute

FATHER
12. Name: Michael Cunningham
13. Birthplace: Lonaconing Md.

MOTHER
14. Maiden name: Bridget Byrnes
15. Birthplace: Midland, Md.

16. Informant: Michael Cunningham
Address: Midland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4, 1948 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg, Md.
18. Funeral director: J. J. Eichhorn
Address: Lonaconing, Md.
19. Oct 5 1948 (Date rec'd by registrar) Janet M. Coal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 Oct 1948 at 12 30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Sept 1948 to 1 Oct 1948 and that I last saw him alive on 1 Oct 1948

	DURATION
Immediate cause of death: Anemia	
Due to: mitral heart disease	
Due to: Rheumatic fever	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —
Autopsy results: none done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: John B. Davis M.D.
M. D. ~~author~~
Address: Lonaconing Md. Date signed 10/2/48

Outside of City Limits

Dr. Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

10011

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Spring Gap (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 years

Hospital, institution, or street address where death occurred: Spring Gap

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Spring Gap (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Louise Davis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife John Davis 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 12, 1868

8. AGE: Years	Months	Days	If less than one day
80	0	15	..... hrs. ..... min.

9. Birthplace Erits Creek, Allegany, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Charles J. Fisher

13. Birthplace Maryland

MOTHER 14. Maiden name Frances Fechtman

15. Birthplace Maryland

16. Informant Bertha M. Davis

Address Spring Gap, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 30, 1948 (month) (day) (year)

Cemetery or crematory Mt. Tabor Cemetery

Location Spring Gap Md.

18. Funeral director John E. Naylor

Address Cumberland, Md.

19. Oct. 30 1948 (Date rec'd by registrar) W. R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1948, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from June 1948 to Oct. 27 1948, and that I last saw her alive on Sept. 15 1948

	DURATION
Immediate cause of death Coronary Thrombosis - Sudden	
Due to Hypertension	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Clayt. Durrett M. D. or other

Address Cumberland Date signed 10/29/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr P. E. Berry 10012

48 L

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

111 Spruce St.

How long in hospital or institution? - - - - - - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 111 Spruce Street

(If rural, give LOCATION)

2.(a) If veteran, name war: - - - - - - -

3.(a) FULL NAME

NINA REBECCA DAVIS

3.(b) Social Security Number

- - - - - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Porter R. Davis

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): June 2, 1888

8. AGE: Years	Months	Days	If less than one day
60	4	5	..... hrs. ..... min.

9. Birthplace: Harrisonburg, Rockingham, Va.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: own home

FATHER 12. Name: Phillip S. Hartman

13. Birthplace: Virginia

MOTHER 14. Maiden name: Sarah E. Jarrels

15. Birthplace: Virginia

16. Informant: Porter R. Davis

Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 10, 1948 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. ~~XXXX~~ Boal

Address: Westernport, Maryland

19. Oct. 10 (Date rec'd by registrar) 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1948 at 3:30p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to Oct. 7 1948 and that I last saw her alive on Oct. 7 1948

Immediate cause of death	DURATION
Coronary Thrombosis	1 Hr.
Due to: Hypertension	
Due to:	
Other conditions: Carcinoma Uterus	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: P.E. Berry M.D.
M. D. or other

Address: Piedmont W. Va. Date signed: 10/9/48

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10013

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Years

Hospital, Institution, or street address where death occurred: Rt, 1. Box 196 LaVale

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt, 1. Box 196 LaVale

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Daniel R. Dawson

3.(b) Social Security Number: 216-14-1939

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 24 1871

8. AGE: Years	Months	Days	If less than one day
77	8	15	..... hrs. ..... min.

9. Birthplace: Great Cacapon, W. Va. Morgan Co. (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: Cumberland Savings Bank

FATHER — 12. Name: Joseph T. Dawson

FATHER — 13. Birthplace: Great Cacapon, W. Va.

MOTHER — 14. Maiden name: Mary Ryan

MOTHER — 15. Birthplace: Allegany Co, Maryland.

16. Informant: W. L. Price

Address: Rt, 1. Box 196, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/12/48 (month) (day) (year)

Cemetery or crematory: Greenway Cemetery

Location: Berkley Springs, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 12 1948 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9 1948, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 st 1948 to Oct 9 1948 and that I last saw him alive on Oct 8 1948

Immediate cause of death	DURATION
Chronic myocarditis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: R. A. Trawski, Jr. M.D. M.D. or other

Address: Cumberland, Md. Date signed: Oct 11-'48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

10014

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Barrows Park (If outside city or town limits, write RURAL and give nearest town)

Street No. La Vale (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Jane Gray Deming

3.(b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Herbert V Deming

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 26 1884

8. AGE: Years 64 Months 8 Days 13 If less than one day ..... hrs. ..... min.

9. Birthplace: Roseboro, Otsego Co N.Y. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: David R Taylor

13. Birthplace: N. Y.

MOTHER 14. Maiden name: Charlotte M. Taylor

15. Birthplace: N. Y.

16. Informant: Dr. H. V. Deming

Address: Cumberland Md.

17. Burial + Removal (Burial, cremation, or removal. Which?) Date thereof Oct 11 48 (month) (day) (year)

Cemetery or crematory: Green Hill Cem.

Location: Amsterdam, N. Y.

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md.

19. Oct 9 1948 (Date rec'd by registrar) W. L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 8 1948 at 1120 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1948 to Oct 8 1948 and that I last saw h.er alive on Oct 8 1948

	DURATION
Immediate cause of death: Coronary Thrombosis	1 day
Due to: Hypertension Cardiovascular Renal	?
Due to:	
Other conditions: Cerebral Hemorrhage - Dysphasia left sided - (Include pregnancy within 3 months of death)	Sept 25 - " "

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Samuel Lenhardt M. D. or other

Address: 55 Broadway St. Date signed 10/8/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within DR R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10015

932

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 119 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
119-DAYS

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. QUEEN CITY HOTEL
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME EDWARD W. DERN

3. (b) Social Security Number 214-05-5182

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SEPARATED

6.(b) Name of husband or wife ANNIE [redacted] Cookley

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) AUGUST 11, ~~1883~~ 1883

8. AGE: Years 65 | Months ~~8~~ 2 | Days ~~14~~ | If less than one day ..... hrs. ..... min.

9. Birthplace MARYLAND Pinto, Allegany Co.
(Town, county, and state)

10. Usual occupation HANDY MAN QUEEN CITY HOTEL

11. Industry or business

FATHER 12. Name ~~JAMES~~ DERN, Robert

13. Birthplace PENNA

MOTHER 14. Maiden name MARY RICE

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVENUE

17. Burial Date thereof Oct 27 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland, Md.

18. Funeral director William N. Kight

Address Cumberland, Md.

19. Oct. 26 1948 W. Beauty, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 25 19 48 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/20/48 19 to 9/25/48 19 and that I last saw h[redacted] alive on 10/25/48 19

Immediate cause of death Myocarditis

Due to Enterocolitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Cumberland Md. Date signed 10/25/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

10016

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 N Liberty St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Baby Deter

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 2 1948 @ 2:20 A.M.

8. AGE: Years	Months	Days	If less than one day
			19 hrs. 40 min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Chas E Deter

13. Birthplace: Cumberland Md

MOTHER — 14. Maiden name: Hilda Potts

15. Birthplace: Cumberland Md

16. Informant: Chas E Deter

Address: Cumberland

17. Burial (Burial, cremation, or removal? Which?) Date thereof Oct 4 48 (month) (day) (year)

Cemetery or crematory: St Peter & Pauls Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Oct. 4 1948 (Date rec'd by registrar) W. R. Beachy, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1948 at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 2 1948 to Oct 2 1948 and that I last saw h.. alive on Oct 2 1948

Immediate cause of death	DURATION
(a) Prematurity,	6 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: R M Schindler M.D. M. D. or other

Address: 41 Liberty St Date signed Oct 3 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

10017

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, institution, or street address where death occurred: 450 Goethe St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 450 Goethe St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eliza E. Doyle

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Thomas J. Doyle
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 9 1874

8. AGE:

Years	Months	Days	If less than one day
74	7	26	..... hrs. ..... min.

9. Birthplace Little Orleans Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. FATHER Name James Higgins
13. FATHER Birthplace Md.
14. MOTHER Maiden name Elizabeth Reel
15. MOTHER Birthplace Md.
16. Informant Thos. J. Doyle
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 7 48 (month) (day) (year)
Cemetery or crematory St Marys Cem.
Location Cumberland
18. Funeral director Louis Stein Inc.
Address Cumberland Md
19. Oct 6 1948 W. L. Franty, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1948 at 6.50 A.M.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Sept 16 1948 to Oct 5 1948
and that I last saw h.. alive on Oct 2nd 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	19 days
Due to:	
Due to: Arterial Hypertension	2 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE R. H. Trevaskis Jr. M.D.
M. D. or other
Address Cumberland Md Date signed Oct 6-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

10918

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cresap Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
117 Meadow Drive, Cresap Park

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cresap Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 117 Meadow Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Adam Durr

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Pearl Root Durr

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): March 5- 1886

8. AGE:

Years	Months	Days	If less than one day
62	6	29	...hrs. ...min.

9. Birthplace: Rowlesburg W.Va.
(Town, county, and state)

10. Usual occupation: Retired-Pipe fitter

11. Industry or business: Celanese Corp. of Am.

FATHER
12. Name: Charles Durr
13. Birthplace: W.Va.

MOTHER
14. Maiden name: Ida Reinhart
15. Birthplace: W.Va.

16. Informant: wife) Mrs. Pearl Root Durr

Address: 117 Meadow Drive, Cresap Park Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 6, 1948 (month) (day) (year)

Cemetery or crematory: HillCrest Burial Park

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Oct. 6 1948 (Date rec'd by registrar) H. V. Deming Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 4 1948 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw him alive on Oct. 4 1948

Immediate cause of death	DURATION
Angina pectoris	at once
Due to Coronary Sclerosis	about 2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M. D. or coroner

Address: Cumberland Md. Date signed: 10-5-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52a

10018

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 DAYS
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 39 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 513 Maryland Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME EVANS, MARY LOUISE MRS

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife EVANS, THOMAS
DECEASED
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEB 14, 1874

8. AGE: Years	Months	Days	If less than one day
74 yrs	7	27	..... hrs. ..... min.

9. Birthplace penna
(Town, county, and state)

10. Usual occupation HWIFE

11. Industry or business

FATHER
12. Name KIMMEL, KEYSER
13. Birthplace PENNA

MOTHER
14. Maiden name WOLLY, EMMA
15. Birthplace PENNA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 14 1948 (month) (day) (year)
Cemetery or crematory Fernduran
Location Fernduran, Penna
18. Funeral director William H. Eichelberger
Address Cumberland, Md.

19. Oct. 13 1948 W. R. Trautz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 11 1948 at 5.30 M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 3-2 1948 to 10-11-1948 and that I last saw her alive on 10-11-1948

Immediate cause of death	DURATION
Emphysema	
Due to Carcinomatosis	
Due to Carcinoma of left kidney	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Hydronephrosis left kidney + carcinoma Date of op. 4-18-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

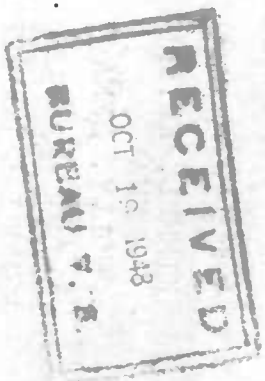
23. SIGNATURE W. F. Hitchins M. D. or other
Address Cumberland Date signed 10/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Mr. Knight



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10019

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Joseph Fazenbaker

3.(b) Social Security Number: 213-01-8801

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nettie Clubaugh Fazenbaker
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Nov 25, 1890

8. AGE:

Years	Months	Days	If less than one day
57	10	27	...hrs. ...min.

9. Birthplace: Lonaconing, Allegany Co. Md. (Town, county, and state)
10. Usual occupation: Mills Truck Driver
11. Industry or business: Fairhill Dairy

FATHER
12. Name: Ralph Fazenbaker
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Fanny Metz
15. Birthplace: Lonaconing Md.

16. Informant: Mrs John J. Fazenbaker
Address: Lonaconing, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof Oct 24 1948 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Moscow, Md.

18. Funeral director: W. J. Eichhorn
Address: Lonaconing, Md.

19. 10-24 1948 Mrs Nancy N Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1948 at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1948 to Oct 22 1948 and that I last saw h... alive on Oct 21 1948

Immediate cause of death	DURATION
Chr Myocarditis	4 mo
Due to Chr Nephritis	several years
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Wm Lane MD M. D. or other
Address: Frostburg Md. Date signed 10-22-48

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160c

10020

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 HOURS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County Grant

City or town PETERSBURG, W. VA.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

FEASTER, BABY GIRL

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCTOBER 15, 1948

8. AGE: Years	Months	Days	If less than one day
			2 hrs. ..... min.

9. Birthplace CUMBERLAND, MD.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name GLENN W. FEASTER

13. Birthplace WEST VIRGINIA

MOTHER

14. Maiden name KEPLINGER, EDNA B.

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE., CITY

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 16, 1948 (month) (day) (year)

Cemetery or crematory Mt. Hebron Cem

Location Petersburg, W. Va.

18. Funeral director P. C. Shrush and Son

Address Petersburg, W. Va.

19. Oct. 15, 1948 (Date rec'd by registrar) W. K. Hantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 15, 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15 1948 to Oct. 15 1948 and that I last saw her alive on Oct. 15 1948

Immediate cause of death	DURATION
prematurity	
premature rupture membranes	
(7 mos.)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. K. Hodge, M.D.

(M.D. or other)

Address Cumberland, Md. Date signed 10/15/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or illegible entry is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

Evidence for change of age shown on:

FILM No. G 118 NOV 22 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10021

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Hours

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt, 6. Potomac Park

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Brown Fielding

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sarah Fielding

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 20 1869

8. AGE: Years	Months	Days	If less than one day
~~78~~ 79	5	21	..... hrs. ..... min.

9. Birthplace: Lake City, Florida (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Construction Worker

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs Joseph Read

Address: Rt, 6. Potomac Park, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/13/48 (month) (day) (year)

Cemetery or crematory: Punta Gorda Cemetery

Location: Punta Gorda, Florida.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct. 12, 1948 (Date rec'd by registrar) W. R. Fauth, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1948 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 11 1948 to Oct 11 1948 and that I last saw him alive on Oct 11 1948

Immediate cause of death	DURATION
Myocardial Infarction	5 hours
Due to: Arteriosclerosis + Hypertensive Heart Disease ?	
Due to:	
Other conditions: Carcinoma of lower Lip (cured) ?	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.: no

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): no

Means of injury: Injured at work?

23. SIGNATURE: Harold A. Greenman M. D. or other

Address: 122 Bedford St Cumberland Date signed: Oct 11, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

10022

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Green St, near Mc Kinley Ave.
How long in hospital or institution? Memorial Hospital Dead on arrival.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 624 Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Fred R. Grove

3.(b) Social Security Number: 214-07-0880

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Nora V. Steigelman Groves
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 3- 1873

8. AGE: Years	Months	Days	If less than one day
75	0	20	..... hrs. ..... min.

9. Birthplace: Williamsport Pa. (Town, county, and state)
10. Usual occupation: employed-Kelly Tire Plant
11. Industry or business

FATHER
12. Name: Abe Grove
13. Birthplace: York County, Penna

MOTHER
14. Maiden name: Susan Bobbitz
15. Birthplace: Adams Co. Penna

16. Informant: Dr. D. B. Brown
Address: 443½ Cumberland St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 26, 1948 (month) (day) (year)
Cemetery or crematory: Hill Crest Cemetery
Location: Cumberland, Maryland
18. Funeral director: John T. Walford
Address: Cumberland Md.

19. Oct. 26 1948 (Date rec'd by registrar) W. K. Fauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23 1948 at 6.17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him Dead Oct. 23 1948

Immediate cause of death: Pulmonary hemorrhage — DURATION: at once

Due to: punctured lung, from fractured ribs, left side of chest.

Due to: hit by an automobile

Other conditions: Both lower legs fractured
Linear fracture of the skull and laceration. Fractured pelvis.
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Auto. accident Date of 10-23-48
Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?) Green St. near McKinley Ave.
Means of injury: Crossing St. hit by Automobile Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. (M. D. or other)
Address: Cumberland Md. Date signed: 10-23-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

Evidence for change of age shown on:

FILM No. G 117 NOV 1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10028

61

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 yrs., 10 mos., 25 days

Hospital, institution, or street address where death occurred:

708 Lincoln St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 708 Lincoln St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ella Sue Gurley

3.(b) Social Security Number: None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Santford A. Gurley

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 22 1876

8. AGE:	Years	Months	Days	If less than one day
	71	10	25	..... hrs. ..... min.

9. Birthplace: Hedgesville, W. Va.

(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER — 12. Name: John W. Harrison

13. Birthplace: Hedgesville, W. Va.

MOTHER — 14. Maiden name: Mary Peregoy

15. Birthplace: Hedgesville, W. Va.

16. Informant: Miss Elosie Gurley

Address: 708 Lincoln St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/19/48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct. 18 19 48 (Date rec'd by registrar) Wm. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17, 1948 at 8.15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..48

and that I last saw her alive on Oct. 17 19..48

Immediate cause of death	DURATION
Arterio-Sclerosis	2 yrs
Due to	
Due to	
Other conditions: Diabetes mellitus	4 yrs
Gangrene of foot (Include pregnancy within 3 months of death)	1 month

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charlotte B. Gardner M. D. or other

Address: Cumberland Md. Date signed 10/18/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10024 Dr. Diehl

46d

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All his life

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George Oliver Hager

3. (b) Social Security Number: none

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 9, 1904

8. AGE: Years: 44 Months: 3 Days: 1 If less than one day: hrs. min.

9. Birthplace: rural Frostburg Garrett, Maryland (Town, county, and state)

10. Usual occupation: Technician

11. Industry or business: Dental laboratory

FATHER — 12. Name: Wm. Hager

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Michaels

MOTHER — 15. Birthplace: Maryland

16. Informant: Charles Hager

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 13, 1948 (month) (day) (year)

Cemetery or crematory: Johnson Cemetery

Location: Frostburg Md.

18. Funeral director: J. R. Oldest

Address: Frostburg Md.

19. 10-13 1948 (Date rec'd by registrar) Mrs. Nancy K. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1948 at 5:30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 15 1948 to October 11 1948 and that I last saw h. I M. alive on October 11 1948.

	DURATION
Immediate cause of death	
Carcinoma of rectum	3 Months.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other

Address: Frostburg, Md. Date signed: 10/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10025

Reg. Dist. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Flintstone (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Flintstone (rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Star Route
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Carrie Etta Harper

3.(b) Social Security Number:

4. Sex: F
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Charles W. Harper
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 4, 1871
8. AGE: Years: 77 Months: 7 Days: 4 If less than one day: hrs. min.
9. Birthplace: Pendleton Co., W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: Elijah Nelson
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Charles C. Harper
Address: Flintstone Md. Star Route
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10, 1948 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: Clarysville W. Va.
18. Funeral director: William H. Knight
Address: Cumberland Md.
19. Oct. 8 1948 (Date rec'd by registrar) Mrs. J. A. Watson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 1948 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25 1948 to Oct. 8, 1948 and that I last saw her alive on Oct. 7, 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to: High Blood pressure	?
Due to:	
Other conditions: Chronic myocarditis	?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Watson M.D.
M. D. or other
Address: Little Orleans Md. Date signed 10/3/48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10026

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: 107 So. Johnson St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 S. Johnson St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sara Ann Hart

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Wm P Hart

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 3 1870.

8. AGE: Years	Months	Days	If less than one day
78	7	6	..... hrs. ..... min.

9. Birthplace Frostburg Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Cook

13. Birthplace Md

MOTHER 14. Maiden name Bertha Pinder

15. Birthplace Md.

16. Informant Miss Bertha Hart

Address Aberdeen Md.

17. Burial Date thereof Oct 14 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Oct. 13, 1948 W. R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Pudyak 10/9/48 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ saw him alive 19..... to 10/11/48 19.....

and that I last saw him alive 10/11/48 19.....

Immediate cause of death	Coronary Heart disease	DURATION
Due to	Coronary Thrombosis	24h
Due to	Arteriosclerosis	
Other conditions	-	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Mattern Coroner
M. D. or other

Address 140 Archfield St Date signed 10/12/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10027

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: 502 Fayette St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 502 Fayette St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Emma Hartsock

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife A Scott Hartsock

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 18 1873

8. AGE: Years	Months	Days	If less than one day
75	9	—	..... hrs. ..... min.

9. Birthplace Bedford Co. Pa.
(Town, county, and state)

10. Usual occupation Housework at Home

11. Industry or business

FATHER 12. Name Wm. G. Hunter

13. Birthplace Md

MOTHER 14. Maiden name Rebecca Hite

15. Birthplace Pa

16. Informant Wm Hunter

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20 48 (month) (day) (year)

Cemetery or crematory Bethel Cem

Location near Bedford Valley Pa

18. Funeral director Louis Stein Sons

Address Cumberland

19. Oct. 19, 1948 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1948 at 855 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8, 1947 to Oct 18 1948 and that I last saw h.er alive on October 17, 1948

Immediate cause of death	DURATION
Acute Myocardial Failure	1 hour
Due to Myocardial disease Coronary Artery disease	3
Due to	
Other conditions Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Samuel J. Jacobson M. D. or other

Address 50 Pershing St. Date signed 10/18/48

VS A15—9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

DR GRACIE
Evidence for correction of middle initial shown on: WW No. G 117 OCT 29 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10628

97

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL Hospital
How long in hospital or institution? 9 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County PRESTON
City or town TERRA ALTA
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME ABRAHAM L. HAYES

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife MARY MOYERS (DECEASED)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT. 11, 1866

8. AGE: Years	Months	Days	If less than one day
82	0	23	..... hrs. ..... min.

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name WILLIAM HAYES
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name CAROLINE HAYES
15. Birthplace W.VA.

16. Informant MEMORIAL Hospital
Address CUMBERLAND, MD.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 4. 1948 (month) (day) (year)
Cemetery or crematory Lake Lark.
Location Terra alta. W.Va (Rural)

18. Funeral director A. F. Collins
Address Terra alta. W.Va

19. Oct 4 (Date rec'd by registrar) 1948 W. R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 4 1948 at 7:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 1948 to Oct 4 1948 and that I last saw him alive on Oct 3 1948

Immediate cause of death	DURATION
a Uremia	
Due to Arteriosclerosis Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations Hypertension Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. L. Graves M. D. or other
Address Cumberland Date signed Oct 4-48

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10029

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 mo.

Hospital, institution, or street address where death occurred: 716 Maple St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 716 Maple St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha Jane Heare

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: J. Jonathan Heare

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 27 1885

8. AGE: Years	Months	Days	If less than one day
63	6	9	..... hrs. ..... min.

9. Birthplace: near Kirby W. Va.

(Town, county and state)

10. Usual occupation: Housewife

11. Industry or business: at Home.

FATHER

12. Name: William Loy

13. Birthplace: W. Va

MOTHER

14. Maiden name: Sarah Starkey

15. Birthplace: W. Va.

16. Informant: Miss Eleanor B Heare

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 8 '48 (month) (day) (year)

Cemetery or crematory: Mt Zion Cem.

Location: near Kirby W. Va.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Oct 8 1948 (Date rec'd by registrar) W. R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6 1948 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 6, 1948 to Oct. 6 1948

and that I last saw h[illegible] alive on Oct. 6. 1948

Immediate cause of death	DURATION
Coronary Thrombosis	15 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Chas. L. Lucas M. D. or other

Address: Cumberland Date signed: 10/6/48.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Dr. Topper

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

10030

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 Days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 Orchard St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alonzo Russell Hensel

3.(b) Social Security Number: 705-05-9226

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Bessie Hager Hensel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 20, 1886

8. AGE: Years	Months	Days	If less than one day
61	9	21	..... hrs. ..... min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: Retired Trackman

11. Industry or business: B. & O. R.R. Co.

FATHER — 12. Name: Henry C. Hensel

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Alice Bell

MOTHER — 15. Birthplace: Cumberland, Md.

16. Informant: Henry C. Hensel

Address: 20 Orchard St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 14, 1948 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Oct. 14 1948 (Date rec'd by registrar) WR-Fantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 11, 1948, at 11:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948 to Oct 11 1948 and that I last saw h... alive on Oct 11 1948

Immediate cause of death	DURATION
Cancer Lung	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John A Topper M.D. (M. D. or other)

Address: Hyndman Pa Date signed Oct 12, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Topper

Outside of City Limits

10031

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 P

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town ~~Bowmans Addition~~ Cumberland Md. rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

home, Bowmans Adda, Rt #3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Near Cumberland rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bowmans Addition Rt. 3

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Flora Emma Hillegass

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12- 1889

8. AGE: Years	Months	Days	If less than one day
59	4	4	hrs. min.

9. Birthplace Kegg Pa. (Town, county, and state)

10. Usual occupation Household duties

11. Industry or business

FATHER

12. Name Lewis Hillegass

13. Birthplace Bedford Co. Pa.

MOTHER

14. Maiden name Anna Lowry

15. Birthplace Bedford Co. Pa.

16. Informant Albert Hillegass

Address R.F.D.#3 Valley Road, Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-18-48 (month) (day) (year)

Cemetery or crematory Schellsburg Cemetery

Location Schellsburg, Pa.

18. Funeral director Harvey F. Bigler

Address Hyndman Penna

19. Oct. 18, 1948 (Date rec'd by registrar) W.K. Fautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1948 at 11.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 1948 to Oct. 16 1948 and that I last saw her alive on Oct. 14 1948

Immediate cause of death	DURATION
Carcinoma of the liver	about 6 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. or other

Address Cumberland Md. Date signed 10-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

DR. FAW

10000

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51b

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 DAYS

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 21 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State ~~MARYLAND~~ Penna County ~~ALLEGANY~~ Bedford

City or town ~~FLINTSTONE~~ Chaneysville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Iverson CHARLES AIMES

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife CARRIE GORDON

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) ~~JULY 6, 1882~~ June 26, 1882

8. AGE: Years	Months	Days	If less than one day
66	2	8	...hrs. ...min.

9. Birthplace Chaneysville PENNsylvania, Bedford Co. (Town, county, and state)

10. Usual occupation FARMER

11. Industry or business Own Farm

FATHER 12. Name ~~DAVID IMES~~ Phillip Imes

FATHER 13. Birthplace PA

MOTHER 14. Maiden name ~~ALVINA~~ Lavinia TRAIL

MOTHER 15. Birthplace PA

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVENUE

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 7, 1948 (month) (day) (year)

Cemetery or crematory Mt. Lake

Location Near Chaneysville, Penna

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Oct. 5 1948 (Date rec'd by registrar) W. K. Fauntz, M.D. Registrar

MEDICAL CERTIFICATION

Sept 15.

20. DATE OF DEATH OCT 4 1948, at 8:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1948, to October 4 1948 and that I last saw him alive on October 4 1948

Immediate cause of death Cachexia — DURATION 6 months.

pathological fracture

femur, right.

Due to Carcinoma, prostate, ? DURATION ?

with multiple skeletal metastasis

Due to ...

Other conditions Suppurative parotitis right DURATION Sept 25, 48

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wyeth Faw M.D. M. D. or other

Address Cumberland Md Date signed Oct 4 '48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

10032

Within corporate limits: Evidence for change of age shown on: DR. FAW.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122 b

FILM No. G 117 OCT 18 1948 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 DAYS

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or Institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. VA County: MINERAL

City or town: RIDGLEY
(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 Knobley
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: SARAH V JOHNSON

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: REASON JOHNSON

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): OCT 15, 1889

8. AGE: Years	Months	Days	If less than one day
58 59	11	23	hrs. min.

9. Birthplace: W. VA
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business:

FATHER
12. Name: ABRAHAM PROPST
13. Birthplace: W. VA

MOTHER
14. Maiden name: SARAH MITCHELL
15. Birthplace: W. VA

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVENUE

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10 1948 (month) (day) (year)

Cemetery or crematory: Fort Ashby Cem.

Location: Fort Ashby, W. Va.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Oct. 9 1948 (Date rec'd by registrar) M. R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT. 8 1948, at 6:55 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 2 1948 to Oct 8 1948 and that I last saw h.. alive on Oct 8 1948

Immediate cause of death	DURATION
Intestinal adhesions	7 yrs.
Intestinal obstruction	8 days.
Due to complete.	
Gangrenous intestine with	
Due to multiple perforations and	
general peritonitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Gangrenous 8 ft terminal ileum with perforation Date of op. Oct 7, 1948

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wyker M Faw Jr M. D. or other

Address: Cumberland Md Date signed Oct 8 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10033

46b

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegay

City or town: Mt. Savage, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Inez Reese Kefauver

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: J. Orville Kefauver

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14th., 1897

8. AGE: Years	Months	Days	If less than one day
51	3	22	hrs. min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: John Reese

13. Birthplace: Wales

MOTHER — 14. Maiden name: Mary Lucy Devore

15. Birthplace: Allegay County, Md.

16. Informant: Mr. J. Orville Kefauver

Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-9-1048 (month) (day) (year)

Cemetery or crematory: Reformed Church Cemetery

Location: Middletown, Md.

18. Funeral director: Jacob Hafer

Address: Frostburg, Md.

19. 10-9- (Date rec'd by registrar) 1948 Vernica McDermitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6 1948 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Oct 6 1948 and that I last saw h[illegible] alive on Oct 6 1948

Immediate cause of death	DURATION
Carcinoma Stomach ?	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. O. Kefauver M. D. or other

Address: Cumberland Date signed: 10/9/48

Evidence for change in birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10034

13/a

FILM No. G 117 OCT 21 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County: Allegany

City or town: Route 1, Paw Paw, W Va (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Route 1, Paw Paw W Va (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alonza J. Kerns

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Eleanor Hausrote Kerns

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): July 6, 1879 1897

8. AGE: Years	Months	Days	If less than one day
57	7	29	hrs. min.

9. Birthplace: Allegany Co. Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Filmore Kerns
13. Birthplace: Allegany Co. Md

MOTHER
14. Maiden name: Hilda Lefler
15. Birthplace: Allegany Co Md.

16. Informant: Mrs. Eleanor Kerns

Address: Route 1, Paw Paw, W Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 8, 1948 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Cumberland, Md.

18. Funeral director: W. H. Light

Address: Cumberland, Md

19. Oct 8 1948 (Date rec'd by registrar) Mrs C.A. Hanhold Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-5-48 19 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 19 47 to 10-5 19 48

and that I last saw him alive on 10-4-48 19

Immediate cause of death	DURATION
Hepatic Cirrhosis	2 yrs
Cardiovascular collapse	3-4 hrs
Due to: Colitis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. I. Armstrong M.D. M. D. or other

Address: Paw Paw, W. Va Date signed: 10-5-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Cumberland

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

10035

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2hrs & 5 mins

Hospital, institution, or street address where death occurred: [redacted] Memorial Hosp

How long in hospital or institution? 2 HRS & 5 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ~~CUMBERLAND MD~~ County MD Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 316 Holland St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME KESSLER BABY BOY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 4 1948

8. AGE: Years	Months	Days	If less than one day
2HRS, 5MIN			2 hrs. 5 min.

9. Birthplace CUMBERLAND MARYLAND ALLEG

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name KESSLER, BERNARD Leo

13. Birthplace MARYLAND

MOTHER 14. Maiden name? CHENOWITCH MARY JANE

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND

17. CREMATION Date thereof Oct. 4 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MEMORIAL HOSPITAL,

Location CUMBERLAND, MD.

18. Funeral director As above

Address

19. Oct. 4 1948 Arl. Stantz M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~(Mo.)~~ OCTOBER 1 1948 at 7 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1948 to Oct. 1948 and that I last saw h..[illegible] alive on Oct 1948

Immediate cause of death	DURATION
5 mo. Premature Ly	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dallas B. Hudgins M. D. or other

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

10636

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 6 mo 3 da

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 115 Decatur St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Winifred King (Sr. Vincent Marie)

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 7 1889

8. AGE: Years	Months	Days	If less than one day
59	7	15	..... hrs. ..... min.

9. Birthplace County Clare, Ireland (Town, county, and state)

10. Usual occupation Registered Nurse and

11. Industry or business Supt - Hospital (Sisters of Charity)

FATHER 12. Name Michael King

13. Birthplace Ireland

MOTHER 14. Maiden name Mary Haley

15. Birthplace Ireland

16. Informant Sister Loretta

Address 115 Decatur St.

17. Burial (Burial, cremation, or removal? Which?) Date thereof Oct 25 48 (month) (day) (year)

Cemetery or crematory St Patricks Cem

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Oct 25 1948 (Date rec'd by registrar) Wm. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1948 at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Oct. 48 1948 to 22 Oct 48 1948

and that I last saw h... alive on 21 Oct. 48 1948

Immediate cause of death Coronary Heart Disease acute Coronary Occlusion — DURATION 7 yrs 8 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Alfred Va Arsdale, M.D. M. D. or other

Address Cumberland, Md Date signed 23 Oct 48

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10037

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 726 Hilltop Drive
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Letitia Lambert

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Francis Lambert

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): November 3, 1907

8. AGE: Years	Months	Days	If less than one day
40	11	10	hrs. min.

9. Birthplace: Carnegie, Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Francis J. Cavanaugh
13. Birthplace: Pa.

MOTHER
14. Maiden name: Mary Manion
15. Birthplace: Pa.

16. Informant: Francis P. Lambert

Address: 726 Hilltop Drive, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 16, 1948 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Oct. 15 1948 W. L. Trautz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 1948 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 30 1946, to Oct. 13 1948 and that I last saw her alive on October 13 1948

	DURATION
Immediate cause of death: Uremia	4 days
Antecedent cause: Nephritis	4 days
Due to: Myocardial degeneration	3 months
Due to: Coronary thrombosis	?
Other conditions: Mitral stenosis & insuff. ?	?
(Rheumatic)	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Samuel Jarboe M.D.
M. D. or other

Address: 50 Parking Pl. Date signed: 10/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

W.F. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

10038

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

434 Pennsylvania Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 434 Pennsylvania Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George Andrew Lapp

3. (b) Social Security Number: 705-05-4779

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Eva Bell McLuckie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 26, 1882

8. AGE: Years	Months	Days	If less than one day
66	5	26	..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany, Maryland

(Town, county, and state)

10. Usual occupation: Pipefitter - Retired

11. Industry or business: B & O Railroad

FATHER

12. Name: Andrew Lapp

13. Birthplace: Germany

MOTHER

14. Maiden name: Margaret E. Wagner

15. Birthplace: Germany

16. Informant: Mrs. William B. Yates

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 25, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Burial Park

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Oct. 25, 1948 (Date rec'd by registrar) W.L. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1948, at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-4-48 to 10-22-48

and that I last saw him alive on 10-22-48

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W.F. Williams M. D. or other

Address: Cumberland Date signed: 10-23-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~ Death

10039

Reg. Dist. No. 9

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County Allegany
   City or town Frostburg
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: Miners Hospital
   Length of mother's stay in County Life
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State Maryland
   County Allegany
   City or town Frostburg
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. 60 Linden St.
   (If RURAL give LOCATION)

3. Name of child Baby Boy Leatherman
4. Date of birth October 12 1948 Hour 11 58 Am M.
5. Sex Male | 6. Twin or triplet No
7. No. of weeks pregnancy 24

FATHER OF CHILD

8. Full name Daniel Thomas Leatherman
9. Color W 10. Age at time of this birth 25 yrs.
11. Usual occupation Textile Worker

MOTHER OF CHILD

12. Full maiden name Esther Alice Jennings
13. Color W 14. Age at time of this birth 29 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
    (b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of None
19. Labor: (a) Complications of None
    (b) Induced? No
20. (a) Was there an operation for delivery? No (Yes or No)
    (b) State all operations, if any
    (c) Did child die before operation?
    During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes Prematurity wt 2 lbs 8 oz
    (b) Maternal causes

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature Hilda Jane Wathey M.D.
    (Specify if M. D., midwife, or other)
    Address Frostburg, Md

23. (a) Burial (Burial, cremation or removal) (b) Date thereof 10-13-1948 (month) (day) (year)
    (c) Cemetery or crematory Allegany Cemetery
24. (a) Funeral director Joseph Hafer
    (b) Address Frostburg, Md

25. (a) 10-13-48 (Date rec'd by registrar) (b) Mrs Nancy K. Roe (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

* See Instruction C on stub.

V. S. A10

Child lived 6 1/4 hours.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10040

CERTIFICATE OF DEATH

Reg. Diat. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63 yrs 5 — 9

Hospital, institution, or street address where death occurred:

106 Greene St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 Greene St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Louis William Tippold

3.(b) Social Security Number 214-05-6679

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Catherine Schellhaus

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 1885

8. AGE: Years	Months	Days	If less than one day
63	5	9	hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Book keeper.

11. Industry or business

FATHER 12. Name Wm L. Tippold

13. Birthplace Jamtd Md

MOTHER 14. Maiden name Mathilda Schoukey

15. Birthplace Pa.

16. Informant Mrs Catherine Tippold

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20 '48 (month) (day) (year)

Cemetery or crematory St Peters + Pauls Cem

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland

19. Oct. 19 1948 W. L. Frantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1948, at 6-45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 16, 1944 to Oct. 17, 1948 and that I last saw him alive on Oct. 16, 1948

Immediate cause of death	DURATION
Myocardial infarction	3½ yrs.
Due to Myocarditis, chronic	3½ yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE O C Zimmerman M.D.
M. D. or other

Address Cumberland, Md. Date signed 10-18-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10041

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs 40 min

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 247 S Centre St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME SHARLEEN ELAINE ~~Baby Girl~~ Logan

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 11 1948

8. AGE: Years | Months | Days | If less than one day: 3 hrs. 40 min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Raymond F. Logan

13. Birthplace: Olean R. G.

MOTHER — 14. Maiden name: Lana Mae Childress

15. Birthplace: Lynchburg Va.

16. Informant: Raymond Logan

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 13 48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Oct. 13 1948. (Date rec'd by registrar) Wm. L. Kantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 11 1948 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 11 1948 to Oct. 11 1948 and that I last saw her alive on Oct. 11 1948.

	DURATION
Immediate cause of death: Sues	(3)
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. M. Schmidt M.D. M. D. or other

Address: 41 Greene St. Date signed: Oct. 14, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

164C

10642

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Rural) Evitts Creek B&O.R.Ry bridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? just a few minutes

Hospital, institution, or street address where death occurred:
Evitts Creek B&O.R.Ry.bridge

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 214 Park St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Virgil L McElfish

3.(b) Social Security Number 705-07-9530

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	divorced

6.(b) Name of husband or wife Eva M. Landis McElfish

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 9 1895

8. AGE: Years	Months	Days	If less than one day
53	5	18	..... hrs. ..... min.

9. Birthplace Rush Md.
(Town, county, and state)

10. Usual occupation B&O.R.Ry.freight conductor.

11. Industry or business B&O.R.Ry.

FATHER
12. Name Luther McElfish
13. Birthplace Rush Md.

MOTHER
14. Maiden name Elizabeth J.Hinkle
15. Birthplace Rush Md.

16. Informant Mrs. Richard Zembower

Address 527 Dryer Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 30, 1948 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland, Md.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. Oct 30, 1948 (Date rec'd by registrar) W.K. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1948 at about 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Oct. 27 1948

Immediate cause of death	DURATION
Intracranial hemorrhage	at once
Due to self-inflicted bullet wound through roof of mouth in skull	
Due to a 32 caliber automatic revolver.	
Other conditions nervousness	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of Oct. 27-48

Where did injury occur? near Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) Evitts Creek bridge R.Ry.

Means of injury as above Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V.Deming M.D. H.V.Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 10-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10043

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (RURAL)
(If outside city or town limits, write RURAL and give nearest town)

Street No. BEDFORD ROAD, R.F.D. 3
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM L. McFARLAND

3.(b) Social Security Number 705-10-7601

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MAUDE V. MICKEY

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) MARCH 4 1876

8. AGE: Years	Months	Days	If less than one day
72	7	26	..... hrs. ..... min.

9. Birthplace W. VA.
(Town, county, and state)

10. Usual occupation MACHINIST — RETIRED

11. Industry or business W.MD. RY

FATHER 12. Name JOHN McFARLAND

FATHER 13. Birthplace W.VA.

MOTHER 14. Maiden name ELLEN CONNER

MOTHER 15. Birthplace PA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. BURIAL Date thereof Nov 2 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory LYBARGER CEM.

Location MADLEY, PA.

18. Funeral director Louis Stein Inc

Address Cumberland

19. Nov. 1 1948 C.R. Fauntz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 30th 1948 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/15/48 19.. to 10/30/48 19..

and that I last saw h.. alive on 10/30/48 19..

Immediate cause of death	DURATION
Coronary thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other

Address [illegible] Date signed 10/31/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10644

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Allegany

City or town near Oldtown, Md. Rickardy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town near Oldtown Md. Rickardy, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. none farm section

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Florence Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	married

6.(b) Name of husband or wife Wm. M. miller

6.(c) If alive, give age 96 years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1862

8. AGE:

Years	Months	Days	If less than one day
85	9	10	hrs. min.

9. Birthplace Preston county, W. Va.

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER

12. Name ? Duvalle

13. Birthplace ?

MOTHER

14. Maiden name ?

15. Birthplace ?

16. Informant Walter Hall

Address Virginia Ave. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 9, 1948 (month) (day) (year)

Cemetery or crematory Miller Cem.

Location Rickardy, Md.

18. Funeral director James F. Scarpelli

Address Cumberland Md.

19. Oct 8 1948 (Date rec'd by registrar) Mrs E. A. Shandoltz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-48 19 at 6:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-4-48 19 to 19 and that I last saw h alive on 10-4-48 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. I. Feaster M. D. M. D. or other

Address Petersburg W. Va. Date signed 10-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

7 21
B-37
1948-X2-7
85-9-10

1863-12-29

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1860

10045

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany Md.

City or town Rural) about 2 miles from Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 16 hours.

Hospital, institution, or street address where death occurred: In Wills Creek N. end of Locust Grove, under B&O.R.Ry. bridge.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Smith St.

(If rurel, give LOCATION)

2.(a) If veleran, name war

3.(a) FULL NAME Louis C. Miller

3.(b) Social Security Number 705-10-7784

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mayme S. Park Miller

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Dec. 15-1887

8. AGE:

Years	Months	Days	If less than one day
60	10	2	...hrs. ...min.

9. Birthplace Scottdale Pa. (Town, county, and state)

10. Usual occupation Conductor for W.Md.R.Ry.

11. Industry or business Elkins Division.

FATHER 12. Name Cornelious Miller

13. Birthplace Ediston Pa.

MOTHER 14. Maiden name Anna Catherine Pressman

15. Birthplace Cumberland, Maryland

16. Informant H. V. Deming, M.D.

Address 125 Bedford St, City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 20, 1948 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director John T. Wolford

Address Cumberland Md

19. Oct. 20 1948 (Date rec'd by registrar) C. A. Trautz, M.D. Registror

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1948 at about 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on Dead Oct. 17 1948

Immediate cause of death Pulmonary hemorrhage — DURATION about 10 Hrs.

Due to a punctured right lung from fractured ribs

Due to a fall from a B&O.R.Ry. bridge 35Ft. into Wills Creek.

Other conditions Cutaneous Emphysema. small puncture wound beneath angle of right jaw, small contusion of scalp

(Include pregnancy within 3 months of death)

Major findings of operation back of right ear. Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 10-16-48

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public highway? bridge. Locust Grove

Means of injury Fell from B&O.R.Ry. Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address Cumberland Md. Date signed 10-18-48

Within corporate limits

10046

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93e

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 Yrs 0 Months 23 Days

Hospital, institution, or street address where death occurred:

6 Wempe Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6 Wempe Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Catherine Robinson Minke

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jacob J. Minke

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 20, 1879

8. AGE: Years	Months	Days	If less than one day
69	0	23	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: "

MOTHER FATHER

12. Name: Jacob Robinson

13. Birthplace: Cumberland, Md.

14. Maiden name: Rachel McKenzie

15. Birthplace: Cumberland, Md.

16. Informant: Thomas E. Minke

Address: 6 Wempe Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/16/48 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: 309-311 Decatur St.

19. Oct 15 1948 (Date rec'd by registrar) Wm. H. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 13 19 48, at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4 19 48 to October 12 19 48 and that I last saw h.. alive on October 12 19 48

Immediate cause of death	Acute Nephritis	DURATION: One week
Due to		
Due to		
Other conditions	Myocarditis	Not Known

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. J. Johnson Jr. M.D. M. D. or other

Address: Cumberland Md. Date signed: 10-14-48

Ds. Johnson

Within corporate limits

10047

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs.

Hospital, institution, or street address where death occurred: Allegany Co Infirmary

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Gilmore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rose Morris

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 18 1871

8. AGE: Years: 77 Months: 4 Days: 13 If less than one day: hrs. min.

9. Birthplace: Gilmore, Allegany Co. Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: — Morris

13. Birthplace: unknown

MOTHER 14. Maiden name: Rhoda Mrs Kunzie

15. Birthplace: unknown

16. Informant: Lillie Morris

Address: 330 Arizona Ave Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4, 48 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Cumberland

18. Funeral director: Louis Stein & Son

Address: Cumberland

19. Oct. 4, 1948 (Date rec'd by registrar) W. R. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 1 1948 at 7 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to Oct. 1 1948 and that I last saw h.er alive on Sept. 28 1948

Immediate cause of death	DURATION
Cerebral Vascular Accident	10 hrs.
Due to: Cerebral Arteriosclerosis & Hypertension	4 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed: 10-1-48

10048

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

Reg. Dist. No. 10

M

1. PLACE OF DEATH:

County Allegany

City or town Mt. Savage Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs

Hospital, institution, or street address where death occurred:
New Row

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No. New Row.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME C. Elizabeth Mulligan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife James J. Mulligan

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) May 7 1879

8. AGE: Years 69 | Months 5 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace Mt Savage Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles Hiner

13. Birthplace Wellsburg, Pa

MOTHER 14. Maiden name Mary Ann Miller

15. Birthplace Mt. Savage, Md

16. Informant Mrs. John Jenkins

Address Mt Savage Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2-48 (month) (day) (year)

Cemetery or crematory St Patricks

Location Mt Savage Md

18. Funeral director J. R. Durst

Address Frostburg Md

19. Nov. 1 1948 (Date rec'd by registrar) Veronica McDermitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1948, at 8 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw her alive Dead Nov. 1 1948

Immediate cause of death Chronic Myocarditis — DURATION 7 yrs.

Due to

Due to

Other conditions Cardio-vascular-renal condition with hypertention. — about 20 yrs
(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 11-1-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

Within corporate limits? YES DR ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

126

10649

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2-DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2-DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town OAKLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME

EDITH R NAIR

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife THOMAS NAIR

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) MARCH 11, 1897

8. AGE: Years	Months	Days	If less than one day
51	6	26	....hrs. ....min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name LYDGE UPHOLD
13. Birthplace MARYLAND

MOTHER
14. Maiden name ——— BELL
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address MEMORILA AVE CITY

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct-9-1948 (month) (day) (year)

Cemetery or crematory Oakland
Location Oakland md

18. Funeral director Emory Boldon
Address Oakland md

19. Oct. 9, 1948 (Date rec'd by registrar) W. L. Fautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 7 1948, at 11:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5 1948 to Oct 7 1948 and that I last saw h[illegible] alive on Oct 7 1948

Immediate cause of death	DURATION
Cardiac failure	
Due to Coronary Occlusion & Myocardial degeneration & Hypertension	
Due to	
Other conditions Obesity	

(Include pregnancy within 3 months of death)

Major findings of operations Laparotomy O.B. with stones — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Cumberland Date signed 10/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

10050

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, Institution, or street address where death occurred: 180 Winebrow St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 180 Winebrow St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elvira Neal

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed.

6.(b) Name of husband or wife Richard Neal

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) about 1868

8. AGE:

Years	Months	Days	If less than one day
80?			..... hrs. ..... min.

9. Birthplace Lumberg Co Virginia

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business —

FATHER

12. Name Porta Hunt

13. Birthplace Unknown

MOTHER

14. Maiden name Unknown

15. Birthplace

16. Informant Rev Floyd T. Hunt

Address Cumberland Md

17. Burial ✕ Removal Date thereof Oct 20 48

(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory Bevilla, Va.

Location Bevilla Va.

18. Funeral director Lewis Stein Sons

Address Cumberland.

19. Oct. 19, 1948 W. K. Frantz, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1948, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1948, to Oct. 15 1948

and that I last saw h— alive on Sept. 1, 1948

Immediate cause of death	DURATION
Chronic Myocarditis	2 yrs
Due to Arteriosclerosis	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas E Lewis M.D.

Address Cumberland M. D. or other

Date signed 10/18/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

DR SIMONS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10051

131a

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

M

I

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 45 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 119 FREDERICK ST (If rural, give LOCATION)

2.(a) If veteren, name war:

3. (a) FULL NAME M. CHARLES PENNINGTON

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	DIVORCED

6.(b) Name of husband or wife: Gertrude Laffey

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MAY 15, 1870

8. AGE: Years	Months	Days	If less than one day
78	5	13	hrs. min.

9. Birthplace (Town, county, and state): W. VA

10. Usual occupation: PARKING LOT Owner

11. Industry or business: AUTOES.

FATHER 12. Name: JOHN W PENNINGTON

FATHER 13. Birthplace: W. VA

MOTHER 14. Maiden name: BETTY JONES

MOTHER 15. Birthplace: ENGLAND

16. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 30 '48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland

18. Funeral director: Long Stein Inc.

Address: Cumberland

19. Oct. 28, 1948 (Date rec'd by registrar) Wm. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT. 28 at 6:48A et 6:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/13 9/13/48 19 to 10/28 19 48 and that I last saw h~~im~~ alive on 10/28/48 19

Immediate cause of death	DURATION
Cardiac decompensation	
Due to: Cardiosclerosis and Diabetes	
Due to: Myocardial degeneration	
Other conditions: Pernicious Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George M. Simons M. D. or other

Address: 128 Union Street Date signed 10/29/48

Within corporate limits

M

C

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157-b

10052

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 days

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 33 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Deer Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. Box 565

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Marshley Lynne Perando.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 13th 1948.

8. AGE: Years	Months	Days	If less than one day
	1	3	..... hrs. ..... min.

9. Birthplace Memorial Hospital, Cumberland, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Benjamin Marquis Perando.

13. Birthplace Kitzmiller, Md.

MOTHER 14. Maiden name Barbara Martin.

15. Birthplace Roswell, New Mexico.

16. Informant Mrs. Barbara Perando.

Address Deer Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 17th/48 (month) (day) (year)

Cemetery or crematory Deer Park Cemetery.

Location Deer Park, Md.

18. Funeral director Emory D. Baldeee,

Address Oakland, Md.

19. Oct 17, 1948 W.K. Fauth, M.W. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16th 1948, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 13 1948, to Oct. 16 1948

and that I last saw her alive on Oct. 15 1948

Immediate cause of death	DURATION
(Non-communicable) Meningocele	
Due to Spina Bifida (Congenital	
Due to	
Other conditions Bilateral Club foot	
Atresia partial left Tricuspid valve of heart	

(Includes pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Fuller B. Hollingsworth M. D. or other

Address 112 Bedford St. Date signed 10-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10053

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

135 Mc Cullah St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 135 Mc Cullah St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ann Elizabeth Sloan Perdue

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Amos Perdue

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Jan. 25 - 1883

8. AGE: Years 65 | Months 9 | Days 12 | If less than one day: hrs. min.

9. Birthplace: Hoffman, Allegany, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: James Sloan

13. Birthplace: Berkley Springs, W. Va.

MOTHER 14. Maiden name: Mary Jane Barnett

15. Birthplace: Cumberland, Md.

16. Informant: Mr. Amos Perdue

Address: 135 Mc Cullah St. Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-11-1948 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg, Md.

18. Funeral director: Jas. H. Waters

Address: Frostburg, Md.

19. 10-9 1948 Mrs. Nancy V. Roe Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7 1948, at 9 3/4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1948 to Oct 7 1948 and that I last saw h alive on Oct 7 1948

Immediate cause of death: Chr Myocarditis — DURATION: Several months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W O M Jane M.D. M. D. or other

Address: Frostburg Md Date signed: 10-8-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

10054

CERTIFICATE OF DEATH

Reg. Dist. No. 9

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: (If outside city or town limits, write RURAL and give nearest town) Eastern

How long in above place of death?

Hospital, institution, or street address where death occurred: Memis Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: (If outside city or town limits, write RURAL and give nearest town) Frostburg Md.

Street No.: 84 Bowery St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hazel Plummer

3. (b) Social Security Number None.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Robert Plummer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 30 - 1893

8. AGE: Years: 55 | Months: 8 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Wm. Steele

13. Birthplace: Pa.

MOTHER 14. Maiden name: Ellen Whitaker

15. Birthplace: Somerset, Pa.

16. Informant: Mrs. Nellie Spangenberg

Address: 84 Bowery St. Frostburg, Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof: Oct. 27-1948 (month) (day) (year)

Cemetery or ~~crematory~~: Allegany

Location: Frostburg, Md.

18. Funeral director: Daniel Gaskey

Address: Frostburg, Md.

19. 10-26 1948 (Date rec'd by registrar) Mary Dawson Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 1948 at 10:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/22 1948 to 10/24 1948

and that I last saw h... alive on 10/24 1948

Immediate cause of death	DURATION
Cerebral Thrombosis	5-2 hrs.
Due to: Chr. Hypertension	15 yrs.
Due to: Generalized Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank T. Hamet M.D. M. D. or other

Address: 52 E. Main St., Frostburg, Md. Date signed: 10/26/48

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10055

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany Rural Md.

City or town R.F.D.6-Roberts Place Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred home

R.F.D 6 Roberts Place, Cumberland Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City Rear Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D.6 Roberts Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME L Oda Potts

3.(b) Social Security Number 217-10-6364

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Cousie Shipley Potts 6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Aug. 15-1897

8. AGE: Years	Months	Days	If less than one day
51	2	0	...hrs. ...min.

9. Birthplace Bedford Co. Pa. (Town, county, and state)

10. Usual occupation Celanese, Acetate Dept.

11. Industry or business Celanese Corp. of Am.

FATHER 12. Name Jonathon Potts

13. Birthplace Bedford Co. Pa.

MOTHER 14. Maiden name Amanda Purcell

15. Birthplace Bedford Co. Pa.

16. Informant Mrs. Cousie Potts

Address Rt. 6, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 17, 1948 (month) (day) (year)

Cemetery or crematory Fairview Christian

Location near Artemas, Pa.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Oct. 17, 1948 (Date rec'd by registrar) Wm. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 19 48 at 1.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw h... im alive Dead Oct. 15 19 48

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. or other

Address Cumberland Md. Date signed 10-15-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. Within corporate limits DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

74a

10056

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CRESAPTOWN, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MASTER THOMAS C. PRATT

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): September 2, 1947

8. AGE: Years 1 | Months 1 | Days 6 | If less than one day ... hrs. ... min.

9. Birthplace MARYLAND, Cumberland, Alleg Co
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name THOMAS L. PRATT

13. Birthplace PENNSYLVANIA

MOTHER 14. Maiden name PHYLISS EMMERT

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11 1948 (month) (day) (year)

Cemetery or crematory St. Ambrose Cem.

Location Cresaptown, Md

18. Funeral director James F. Scapelli

Address Cumberland, Md

19. Oct. 8 1948 (Date rec'd by registrar) W. K. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 8, 1948 at 2:10A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to 8 Oct 19 48

and that I last saw him alive on 6 Oct 19 48

Immediate cause of death	DURATION
Leukemia (unknown)	
Due to	
Due to	
Due to	
Other conditions Splenomegaly / Splenomegaly	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Fuller B. Shelburne M. D. or other

Address Date signed 8 Oct 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

10057

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 323 Baltimore Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sadye Price

3.(b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 8 1873

8. AGE: Years 75 | Months 3 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Lonaconing Allegany Md. (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER

12. Name Charles Price

13. Birthplace Germany

MOTHER

14. Maiden name Bithie Meyers

15. Birthplace Germany

16. Informant Mrs Sylvia Schwab

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11 48 (month) (day) (year)

Cemetery or crematory East View Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Oct. 11 1948 W. K. Gaunty M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1948 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5 1948 to Oct 9 1948 and that I last saw h.. alive on Oct 8 1948

	DURATION
Immediate cause of death: Generalized peritonitis	24 hrs.
Due to: Perforated Carcinoma of Sigmoid	?
Due to:	
Other conditions: Cirrhosis of liver	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Jenkins M.D. M. D. or other

Address 115 S. Centre St Date signed 10-9-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10058

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Years

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? Six Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 Decatur Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Albert Reagan

3.(b) Social Security Number: 705-12-0913

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Theresa E. Reagan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 30 1874

8. AGE: Years	Months	Days	If less than one day
74	8	20	..... hrs. ..... min.

9. Birthplace: Mt Savage, Allegany Co, Maryland.

(Town, county, and state)

10. Usual occupation: Boiled Maker

11. Industry or business: Baltimore & Ohio Railroad

FATHER

12. Name: Jermiah Reagan

13. Birthplace: Cumberland, Md.

MOTHER

14. Maiden name: Catherine Oakes

15. Birthplace: Virginia

16. Informant: Miss Catherine Reagan

Address: Corner Hilton & Clifton Ave Wallbrook, Baltimore, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/29/48 (month) (day) (year)

Cemetery or crematory: St Patricks Cemetery

Location: Mt Savage, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct. 28, 1948 (Date rec'd by registrar) Robt. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 1948, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: ..... M. D. or other

Address: ..... Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A-15 9-45-15M

Within corporate limits

Van Ormer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore • 131a

10059

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carl Christy Rice

3.(b) Social Security Number 214-07-5128

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Edith Fisher

6.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) August 16, 1911

8. AGE: Years	Months	Days	If less than one day
37	2	13	..... hrs. ..... min.

9. Birthplace Cumberland Allegany, Md.
(Town, county, and state)

10. Usual occupation Bobbin Stores Foreman

11. Industry or business Celanese Corp.

FATHER
12. Name Harry G. Rice
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden name Mary Jane Borden
15. Birthplace Cumberland, Md.

16. Informant Mrs. Edith Rice
Address Rt 1, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 1, 1948 (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Nov 1, 1948 (Date rec'd by registrar) W. L. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948 at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from mar 5th. 47 19.. to 29 oct 19 45

and that I last saw h.. alive on 29 oct. 45 19..

Immediate cause of death	DURATION
Hypertensive vascular disease	
Due to, or as a consequence of: Chr Nephrosclerosis ? and Retinal Failure	
Due to, or as a consequence of:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. A. Van Ormer M. D. or other

Address Cumberland Md Date signed 30 oct. 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10060

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State W.VA County Morgan

City or town PAW. PAW
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME ROBERTSON, LAURA MRS

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	Married

6.(b) Name of husband or wife ROBERTSON, HARRISON

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) MARCH 18 1891

8. AGE: Years	Months	Days	If less than one day
57	6 (March)	13	...hrs. ...min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER — 12. Name GRACIE, JAMES
13. Birthplace MARYLAND

MOTHER — 14. Maiden name GASTER, MARGARET
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD

17. Burial Date thereof 10/4/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Ridge Cemetery

Location Green Ridge, Md.

18. Funeral director W. D. Parks

Address Berkley Springs, W. Va.

19. Oct. 4 19 48 W. A. Trapp, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2/48 19... at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/16/48 19... to ...19...

and that I last saw her alive on ...19...

Immediate cause of death	DURATION
Myocardial Fantenop	
Due to Enlarged heart, first degree block & Arteriosclerosis	
Due to Pneumonia	
Due to Diabetes	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE R. H. Williamson M.D.
M. D. or other

Address Cumberland, Md. Date signed 10/4/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10061

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

213 Centre St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town 213 Centre St. Frostburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Minnie Alice Robertson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Ressley Robertson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 2nd. 1880

8. AGE:

Years	Months	Days	If less than one day
68	9	17	..... hrs. ..... min.

9. Birthplace Pan Pan, W. Va.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER

12. Name Lafayette Early

13. Birthplace Virginia

MOTHER

14. Maiden name Sarah Stranidge

15. Birthplace Unknown

16. Informant Homer Robertson

Address 150 Ephrain St. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-22-48 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. 10-22 1948 Mrs. Harvey H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11 1948 to October 19 1948 and that I last saw h.. alive on October 18 1948

	DURATION
Immediate cause of death Cerebral Hemorrhage	7 days
Due to Hypertension	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. D. Gatton M.D.
M. D. or other

Address Frostburg, Md. Date signed 10/20/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Gatton

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

10062

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:
Wood Street Extended

How long in hospital or institution? - - - - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Franklin - rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 mile North of Westernport
(If rural, give LOCATION)

2.(a) If veteran, name war - - - - - - - -

3.(a) FULL NAME: MARY JANE ROSS

3.(b) Social Security Number: - - - - - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Samuel Ross

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): February 20, 1898

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
50	7	21		

9. Birthplace: Elizabeth, Wood, West Virginia
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: own home

FATHER
12. Name: Jacob Gregory
13. Birthplace: Minnesota

MOTHER
14. Maiden name: Josephine Muhlenex
15. Birthplace: West Virginia

16. Informant: Mr Samuel Ross
Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14 1948 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

16. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. Oct. 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to Oct 11 1948

and (that) I last saw her alive on Oct 11 1948

Immediate cause of death	DURATION
Carcinoma of breast	2 yrs
Due to	
Due to	
Other conditions: Diabetes mellitus	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James [illegible] Jr M.D.
M. D. or other

Address: Piedmont W. Va. Date signed: Oct 11 1948

MARYLAND STATE DEPARTMENT OF HEALTH

Dr Paul A. Wilson

2411 N. Charles St., Baltimore

572

CERTIFICATE OF DEATH

Reg. Dist. No. 6

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred: 106 Cromer St

How long in hospital or institution? - - - - - - - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 106 Cromer St

(If rural, give LOCATION)

2.(a) If veteran, name war - - - - - - - - -

3.(a) FULL NAME: ROBERT WALTER SANTMYER

3.(b) Social Security Number: - - - - - - - - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: - - - - - - -

6.(c) If alive, give age: - - - years

7. Birth date of deceased (mo., day, yr.): February 15, 1932

8. AGE: Years	Months	Days	If less than one day
16	9	16	.....hrs. .....min.

9. Birthplace: Keyser, Mineral, W. Va. (Town, county, and state)

10. Usual occupation: Student

11. Industry or business: - - - - - - - - - -

FATHER 12. Name: Robert L. Santmyer

FATHER 13. Birthplace: Keyser, W. Va.

MOTHER 14. Maiden name: Eleanor Blubaugh

MOTHER 15. Birthplace: Lonaconing, Maryland

16. Informant: Calvin Carder

Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4 1948 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. Oct. 4 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1948 to Oct 1 1948 and that I last saw h...m alive on Oct. 1 1948

Immediate cause of death	DURATION
Tumor of Brain and other parts of the Central Nervous system of unspecified origin	2 Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul A. Wilson M.D.

M. D. or other

Address: Piedmont W. Va. Date signed: Oct. 2, '48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

55a 10064

Reg. Dist. No. 4

1454

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Years

Hospital, institution, or street address where death occurred:

Sylvan Retreat

How long in hospital or institution? 10 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 324 Grand Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William George Schell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 21 1868

8. AGE: Years	Months	Days	If less than one day
80	0	10	hrs. min.

9. Birthplace: Burlington, Mineral Co, West Virginia

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER — 12. Name: William E. Schell

FATHER — 13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Mary Jane Bradford

MOTHER — 15. Birthplace: West Virginia

16. Informant: Mrs. T. E. Morrison

Address: 305 Arch St, Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 2 1948 (month) (day) (year)

Cemetery or crematory: Burlington Cemetery

Location: Burlington, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Nov 2 1948 (Date rec'd by registrar) Hunter A. Trail, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1948 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1946 to Oct. 31 1948 and that I last saw him alive on Oct. 29 1948

Immediate cause of death	Fibro Sarcoma Thigh	DURATION 10 wks
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed 11-1-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

10065

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 5 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Olympia Hotel
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clarence Elmer Seitz

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2- 1879

8. AGE: Years	Months	Days	If less than one day
69	0	24	hrs. min.

9. Birthplace Louisville Ky.
(Town, county, and state)

10. Usual occupation electrician for the

11. Industry or business George Clyde Smith Shows.

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant George C. Smith

Address 225 S. Smallwood St., Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29, 1948 (month) (day) (year)

Cemetery or crematory Zion Memorial Cem.

Location Cumberland, Md.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. Oct. 29 1948 (Date rec'd by registrar) Hunter R. Trent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1948 at 5.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

aed that I last saw h... im alive Dead Oct. 26 1948

Immediate cause of death	DURATION
Carcinoma of the sigmoid	11 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

~~Deputy Medical Examiner Allegany Co~~

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. (Other)

Address Cumberland Md Date signed 10-26-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124 b

10066

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Allegany

City or town: Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Miners Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME

Marshal Shearer

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): Oct 30, 1900

8. AGE: Years	Months	Days	If less than one day
47	11	19	— min.

9. Birthplace: Midland Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: John Hinkleys farm

FATHER — 12. Name: David Shearer

13. Birthplace: Gilmore, Maryland

MOTHER — 14. Maiden name: Rosanne Robertson

15. Birthplace: Midland, Md.

16. Informant: David Shearer

Address: Midland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26 '48 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Mr. Eichhorn

Address: Lonaconing, Md.

19. 10-21 1948 (Date rec'd by registrar) Md. Vault N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/19 1948 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/16 1948 to 10 1948 and that I last saw h. alive on 10/18 1948

Immediate cause of death	OURATION
toxemia from cirrhosis of liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Eugene Frye M.D.
M.D. or other

Lonaconing, Md. Date signed 10/21/48

10067

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46d

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany.
City or town: Luke.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Allegany.
City or town: Luke.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME: William Black Smith.

3.(b) Social Security Number: 232-01-1347

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married.

6.(b) Name of husband or wife: Mrs. Agnes Shade Smith.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 5, 1884.

8. AGE: Years	Months	Days	If less than one day
64	1	5	hrs. min.

9. Birthplace: Scotland.
(Town, county, and state)
10. Usual occupation:
11. Industry or business: Pied. Foundry & Machine Co.

FATHER
12. Name: Robert Smith.
13. Birthplace: Scotland.

MOTHER
14. Maiden name: Isabella Black.
15. Birthplace: Scotland.

16. Informant: Mrs. William Smith.
Address: Luke, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 13, 1948. (month) (day) (year)
Cemetery or crematory: xxxx Philos Cemetery.
Location: Westernport, Maryland.

18. Funeral director: W Harold Fedlock Jr
Address: Piedmont, West Va.

19. Oct. 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10, 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to Oct 10 1948 and that I last saw him alive on Oct 10, 1948.

Immediate cause of death	DURATION
Primary sarcoma of rectum	3 yrs
Due to	
Due to	
Other conditions: Diabetes mellitus	15 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James W Smith J MD M. D. or other
Address: Piedmont W. Va. Date signed: 10-12-48

Within corporate limits

WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10068

92d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 DAYS

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 20 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: PENNA County: Bedford

City or town: BEDFORD, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. #4
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MRS. LUCY B. SPRIGGS

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: EMANUEL H. SPRIGGS

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): OCT. 20 - [redacted] 1877

8. AGE: Years	Months	Days	If less than one day
71	0	0	...hrs. ...min.

9. Birthplace: BEDFORD County, Pennsylvania
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: WILLIAM THOMPSON
13. Birthplace: PENNA

MOTHER
14. Maiden name: RACHEAL [redacted] Calhoun
15. Birthplace: PENNA

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVE.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 23, 1948 (month) (day) (year)

Cemetery or crematory: Burning Bush Cem.

Location: Bedford Valley, Penna

18. Funeral director: Lutzel Funeral Home

Address: Bedford Penna - Louis Lutzel

19. Oct. 22, 1948 (Date rec'd by registrar) W. R. Fantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 20 1948 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-10-1948, to 10/20 1948 and that I last saw h[illegible] alive on 10-20- 1948

Immediate cause of death	DURATION
Chronic valvular heart disease.	
Due to: Chronic myocardial degeneration	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jno. F. Williams M. D. or other

Address: Cumberland, Md. Date signed 10/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10069

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55a

CERTIFICATE OF DEATH

Reg. Dist. No. 6

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 weeks

Hospital, Institution, or street address where death occurred: 518 B. Md. Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: West Va County: Grant

City or town: Maysville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Anna Vuelta Stonestreet

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

B.(b) Name of husband or wife: Leonard Stonestreet

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 18, 1919

8. AGE:

Years	Months	Days	If less than one day
29	3	16	hrs. min.

9. Birthplace: Maysville Grant W. Va. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: Robert Keplinger

13. Birthplace: maysville W. Va.

MOTHER

14. Maiden name: Bessie Almira Rohrbaugh

15. Birthplace: Jordan's Run, W. Va

18. Informant: Dorothy Marsh

Address: westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/6/48 (month) (day) (year)

Cemetery or crematory: Maysville Cem

Location: Maysville Md.

18. Funeral director: Earle Bevel

Address: Petersburg W Va

19. Oct 9 1948 [illegible] Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4, 1948, at 2a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4 1948, to October 4 1948

and that I last saw h.r.a. alive on October 3, 1948

Immediate cause of death: Carcinoma of Abdomen — DURATION: 7 mo

Due to: Dermoid Cyst spread in abdomen — DURATION: 7 mo.

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Dermoid cyst removed — Date of op. March-1948

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: P E Berry M.D. M. D. or other

Address: Piedmont W Va Date signed: 10/4/48

ANDERSON J. FAZENBAKER, M. D.

REG. NO. 1857

WESTERNPORT, MD.

Name _____ Age _____

Address _____ Date 10/9/48

Rx

Dr. Berry mailed the death certificate to the undertaker at Petersburg, W. Va. who returned same for burial permit — I was notified about error.

_____ M. D.

THIS PRESCRIPTION CAN BE FILLED AT
KELLY'S PHARMACY

PHONE 3511 WESTERNPORT, MD.

R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10070

83a

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL, CUMBERLAND, MD.
How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town DEER PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME GEORGE Washington TASKER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Widowed

6.(b) Name of husband or wife GRACE HENLINE Tasker
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) APRIL 25, 1886

8. AGE: Years	Months	Days	If less than one day
62	6	0	hrs. ... min.

9. Birthplace MARYLAND Deer Park, Garrett Co
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name ~~ARCH~~ TASKER, Archibald Chisholm
13. Birthplace MARYLAND, Garrett County

MOTHER
14. Maiden name VINA GRUBB
15. Birthplace Unknown

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28-1948 (month) (day) (year)
Cemetery or crematory Deer Park Tasker Family
Location near Deer Park Md

18. Funeral director Emery Baldwin
Address Oakland Md

19. Oct 25 1948 W. R. Beauty M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 25, 1948 at 11:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/22/1948 to 10/25/1948
and that I last saw h... alive on 10/25/1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE R. Williams M. D. or other
Address Med Bldg Cumberland Date signed 10/25/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10071

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If ontside city or towe limits, write RURAL and give nearest town)
How long in above place of death? 10 weeks
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 10 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or towe limits, write RURAL and give nearest town)
Street No.: 1107 Virginia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: SOPHORA THOMAS

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George Thomas
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 8, 1857

8. AGE: Years	Months	Days	If less than one day
91	4	0	____ hrs. ____ min.

9. Birthplace: Wales (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:
FATHER 12. Name: John Edwards,
13. Birthplace: Wales
MOTHER 14. Maiden name: Elizabeth Harvard,
15. Birthplace: Scotland
16. Informant: Mrs. Sarah E. Keller,
Address: Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10, 1948 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery,
Location: Frostburg, Md.
18. Funeral director: J. R. Durst,
Address: Frostburg, Md.
19. 10-9 1948 Mrs. Nancy V. Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 1948 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 1948, to October 8 1948
and that I last saw her alive on October 7 1948

	DURATION
Immediate cause of death: Hypertensive Heart Disease	10 yrs or more
Due to: Arteriosclerotic, generalized.	20 yrs. or more
Due to:	
Other conditions: Senile Psychosis	3 mos

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 48 Broadway Frostburg Date signed: 10/8/48

Within corporate limits of Cumberland

Dr Jacobson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10072

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL Hospital

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. KELLY BLVD, APPARTMENTS
(If rural, give LOCATION)

2.(a) If vntnran, name war

3.(a) FULL NAME PAUL W. THOMPSON

3.(b) Social Security Number 200-18-4166

4. Sex	5. Color or race	6.(a) Singin, marrind, widownd, or divorcnd
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceasnd (mo., day, yr.) JUNE 11 - 1900

8. AGE: Ynars 48 | Months 4 | Days 8 | If less than onn day hrs. min.

9. Birthplace OHIO
(Town, county, and state)

10. Usual occupation BOOK SALESMAN

11. Industry or business

FATHER
12. Name WILLIAM THOMPSON
13. Birthplace NEW JERSEY

MOTHER
14. Maiden name FANNY HOLLAR
15. Birthplace OHIO

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-25-48 (month) (day) (year)

Cemetery or crematory Allegany County Cemetery
Cumberland, Md.

Location

18. Funeral director John C Holford
Address 125 S Liberty St.

19. Oct. 19 1948 (Date rec'd by registrar) Clerk-County Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 19 1948 at 11:10 AM

21. I CERTIFY that death occurred on the date above statnd: that I attended deceased from 10/5 1948 to 10/19 1948 and thal I last saw h/m alive on 10/19/48 1948

	DURATION
Immediate cause of death: Uremia	
Due to: Cardio vascular renal disease	
Due to:	
Other conditions: Raynaud's Disease	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Msnns of injury Injurnd at work?

23. SIGNATURE George M. Jemmon M. D. or other

Address 128 Union Street Date signed 10/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2737

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 1a

10673

CERTIFICATE OF DEATH

Reg. Dist. No. 6

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Allegany.

City or town: Westernport.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Hammond

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie Jane Tonry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles Tonry

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 1 1856

8. AGE: Years	Months	Days	If less than one day
92	5	22	..... hrs. ..... min.

9. Birthplace: Westernport, Allegany Md.

(Town, county, and state)

10. Usual occupation: House-wife

11. Industry or business

FATHER

12. Name: Joseph Campbell

13. Birthplace: Scotland.

MOTHER

14. Maiden name: Katherine Dowry.

15. Birthplace: Scotland.

16. Informant: Robert Tonry.

Address: Fairmont, West Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 26-1948. (month) (day) (year)

Cemetery or crematory: Philos Cemetery.

Location: Westernport, Md.

18. Funeral director: W. Hamil Fridley

Address: Piedmont, West Va.

19. Oct. 26 1948 R. Raymond Bor MD

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1948 19 at 3:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 1946 to October 23 1948, and that I last saw her alive on October 23, 1948

Immediate cause of death	DURATION
Cardio-Vascular-Renal disease	4 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE O E Berry M.D. M. D. or other

Address Piedmont W Va Date signed 10/25/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10074

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

88 Ormond St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 88 Ormond St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Frederick Wade

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lillie Wade

6.(c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) Apr. 18 - 1863

8. AGE: Years 85 | Months 6 | Days 4 | If less than one day hrs. min.

9. Birthplace Frostburg Allegany, Md.

(Town, county, and state)

10. Usual occupation Retired Baker

11. Industry or business

FATHER 12. Name Edmond Wade

13. Birthplace Washington

MOTHER 14. Maiden name Anna Bell

15. Birthplace Ireland

16. Informant Mrs. George Reno

Address 241 Hillside Ave., Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-25-1948 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Jas. F. Wade

Address Frostburg, Md.

19. 10-25-1948 (Date rec'd by registrar) Mrs. Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1948 to Oct 22 1948 and that I last saw h.... alive on Oct 15 1948

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to Coronary Sclerosis	several months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane M.D. M. D. or other

Address Frostburg Md Date signed 10-22-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
OCT 29 1948
BUREAU

DR. JACOBSON

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b

10075

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 38 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County MINERAL COUNTY
City or town PIEDMONT
(If outside city or town limits, write RURAL and give nearest town)
Street No. 60 E. HAMPSHIRE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME MR. WILLIAM A. WASHINGTON

3. (b) Social Security Number 232-26-1591

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	WIDOWER

6.(b) Name of husband or wife FRANCES CLIFFORD
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCTOBER 23, ~~1870~~ 1869

8. AGE: Years	Months	Days	If less than one day
78	11	~~27~~ 17	..... hrs. ..... min.

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual occupation RETIRED
11. Industry or business

FATHER
12. Name EDWARD WASHINGTON
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name SALLY WASHINGTON
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address MEMORIAL AVENUE

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 14 1948 (month) (day) (year)
Cemetery or crematory Thorn Rose Cemetery
Location Keyser, W. Va
18. Funeral director Edmonds & Beal
Address Hectorstpet, Md.

19. Oct. 12 1948 (Date rec'd by registrar) W. L. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 10, 1948 at 6:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 1948, to Oct 10 1948 and that I last saw h[illegible] alive on Oct 9 1948

Immediate cause of death	DURATION
(a) Uremia	3 days
Due to (b) Myocardial disease & decompensation	?
Due to (c) Coronary Artery disease	?
Other conditions Chronic Glomerulonephritis (Include pregnancy within 3 months of death)	—

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Samuel Jacobson M. D. or other
Address 50 Pershing St Date signed 10/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10076

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 minutes

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 324 Cecelia St.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Oscar Wilson Wertz

3.(b) Social Security Number: 214-07- 2085

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Alice Simmons Wertz

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): May 22 - 1913

8. AGE: Years	Months	Days	If less than one day
35	5	9	..... hrs. ..... min.

9. Birthplace: Chaneysville Pa. (Town, county, and state)

10. Usual occupation: Machinest helper

11. Industry or business: B&O R.Ry. Bolt & Forge Plant.

FATHER 12. Name: Valentine Wertz

13. Birthplace: Chaneysville Pa,

MOTHER 14. Maiden name: Arrena Bennett

15. Birthplace: Chaneysville, Pa.

16. Informant: Mrs. Oscar W. Wertz

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 3, 1948 (month) (day) (year)

Cemetery or crematory: Chaneysville

Location: Chaneysville Pa

18. Funeral director: John J Hafer

Address: Cumberland Md.

19. Nov. 2, 1948 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 31, 1948 at 7.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... im alive Dead Oct. 31, 1948

Immediate cause of death	DURATION
Intracranial hemorrhage	about 1 hour
Due to a fracture of the skull	
Due to an automobile accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: auto accident Date of 10-31-48

Where did injury occur? near Rawlings (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) Route 220

Means of injury: Car went out of Control No.

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D. (M. D. or other)

Address: Cumberland Md. Date signed 11-1-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10077

932

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 Yrs

Hospital, Institution, or street address where death occurred:

Memorial Hospital, Cumberland, Md.

How long in hospital or institution? 4 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 632 Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna Elizabeth White

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Warren C White

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1864

8. AGE: Years	Months	Days	If less than one day
84	8	20	..... hrs. ..... min.

9. Birthplace Bedford Co. Penn. (Town, County, and State)

10. Usual occupation House Wife

11. Industry or business

FATHER 12. Name John Ellenberger

13. Birthplace Bedford Co, Penn.

MOTHER 14. Maiden name Julia Weiant

15. Birthplace Unknown

16. Informant O. Carl White

Address 881 Braddock Rd Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-12-48 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director John E Wolford

Address Cumberland Md

19. Oct. 12, 1948 (Date rec'd by registrar) W. L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1948 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Ten Years 19.. to Oct. 10, 1948 and that I last saw her alive on October 10, 1948

Immediate cause of death	DURATION
Cardiac Dilation	
Due to Chronic Myocarditis	5 Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. L. Cumberland M. D. or other

Address 41 Green St. Date signed Oct. 11/48

Within corporate limits

Dr. Irwin Sr.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

10078

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ Hrs.

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 204 Greene St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ralph Willard

3.(b) Social Security Number: 217-14-4123

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary E. Wegman Willard

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1868

8. AGE: Years	Months	Days	If less than one day
80	0	2	..... hrs. ..... min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)

10. Usual occupation: Trust Officier

11. Industry or business: Second National Bank

FATHER — 12. Name: John Perry Willard

FATHER — 13. Birthplace: Hagerstown, Maryland

MOTHER — 14. Maiden name: Mary Ann Reed

MOTHER — 15. Birthplace: Cumberland, Maryland

16. Informant: Mr. Daniel D. Willard

Address: 204 Greene St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 15, 1948 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Oct. 14 1948 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 12, 1948 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Oct 12 19 48 to Oct 12 19 48 and that I last saw h[illegible] alive on Oct 12 19 48

Immediate cause of death	DURATION
Coronary occlusion	3 Hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. A. Trewaski M.D.

M. D. or other

Address: Cumberland Md Date signed: 10/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10079

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Rural) Highway near Barrelsville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? at once

Hospital, institution, or street address where death occurred: as above-

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 Schley St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Williams

3.(b) Social Security Number: 216-22-5034

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Helen Gillette

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Aug. 22- 1895

8. AGE:

Years	Months	Days	If less than one day
53	1	15	..... hrs. ..... min.

9. Birthplace: Ocean Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Musician

11. Industry or business: Teacher of music

FATHER

12. Name: Danial Williams

13. Birthplace: Wales

MOTHER

14. Maiden name: Jane Price

15. Birthplace: Mt. Savage Md.

16. Informant: wife) Mrs. Joseph Williams

Address: Cumberland Md. 220 Schley St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/11/48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 7 1948 (Date rec'd by registrar) Veronica McDermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 7 1948 at about 6.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him Dead Oct. 7 1948

Immediate cause of death: Intracranial hemorrhage — DURATION: at once

Due to: a depressed fracture of the skull.

Due to: Auto. ran off of road and hit a tree, on slight curve.

Other conditions: Fracture of both femurs & right clavicle, also 5 ribs Rt. chest, Several lacerations
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Auto. accident Date of injury: 10-7-48

Where did injury occur? 1/4 mile east of Barrelsville (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): highway, as above

Means of injury: as above Injured at work? way home

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed: 10-7-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10080

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77-8-24

Hospital, institution, or street address where death occurred: Sylvan Retreat

How long in hospital or institution? 1 yr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 358 Bedford St.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Frederick D. Wilson

3.(b) Social Security Number 217-10-5754

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Katherine Wagner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 2 1876

8. AGE: Years	Months	Days	If less than one day
77	8	24	..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Retired

FATHER 12. Name Edward Wilson

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace

16. Informant Mrs Katherine F. Wilson

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 29 48 (month) (day) (year)

Cemetery or crematory Evergreen Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Oct. 28 1948 W. R. Beatty M.D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1948 at 8 45 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1948 to Oct. 26 1948 and that I last saw him alive on Oct. 24 1948

Immediate cause of death	DURATION
Coronary Occlusion	3 Days
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Arthur F. Jones M.D. M. D. or other

Address 110 S. Centre St. Date signed 10-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10681

119a

Reg. Dist. No. 4

PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County Grant
City or town MT. STORM
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MASTER KENNETH EDWARD WOLFE, JR.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY 9, 1948

8. AGE: Years	Months	Days	If less than one day
	3	19	..... hrs. ..... min.

9. Birthplace MT. STORM, W.VA.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name KENNETH EDWARD WOLFE, SR.
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name ZOULA MAE GEORGE
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address MEMORIAL AVE., CITY

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 30, 1948 (month) (day) (year)
Cemetery or crematory Rosel Cemetery
Location Rosel Scheer, Grant Co., W. Va.

18. Funeral director Otha F. Shaeffer
Address Blaine, W. Va.

19. Oct. 29, 1948 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 28, 1948 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 18 1948 to Oct 28 1948
and that I last saw him alive on Oct 27 1948

Immediate cause of death	DURATION
Respiratory infection	3 wks
Due to Malnutrition	8 wks
Due to Pneumonia	10 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. W. Emerson M. D. or other
Address 136 Prem St Cumberland Md Date signed 10/29/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10082

CERTIFICATE OF DEATH

940

Reg. Diat. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Station Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Station
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elijah Clark Wolford

3.(b) Social Security Number: 712-14-1617

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Virgie Fiddle

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 27 - 1873

8. AGE:

Years	Months	Days	If less than one day
74	0	3	hrs. min.

9. Birthplace: Glenville, W. Va.
(Town, county, and state)

10. Usual occupation: Retired Railroader

11. Industry or business: Ex P R R Co

FATHER
12. Name: Peter W. Wolford
13. Birthplace: Glenville W. Va.

MOTHER
14. Maiden name: Margaret Shrensky
15. Birthplace: Glenville W. Va.

16. Informant: Mrs. Jane Aldridge
Address: Station, Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 3 - 1948 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Mt. Savage, Md.

18. Funeral director: Daniel Kafer

Address: Frostburg, Md.

19. Nov 3 1948 (Date rec'd by registrar) Jennie M. Dennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 30th 1948 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-15 1948, to 10-23 1948

and that I last saw him alive on 10-23 1948

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to:	
Due to:	
Other conditions: Vascular Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William E. Moseley M.D.
M. D. or other

Address: Mt Savage Md. Date signed: 11-1-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15